3 Health Care Providers of the Healing Arts Program Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by health care providers of the healing arts as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Claims payment.
- Prior authorization (PA).
- Covered/non-covered services for:
  - Chiropractors.
  - Dieticians.
  - Occupational therapists.
  - Physical therapists.
  - Podiatrists.
  - Radiology technicians.
  - Social workers.
  - Speech-Language Pathologists
- Electronic and paper claims billing.

3.1.2 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS box on the CMS-1500 claim form or in the appropriate field of the electronic claim form. Not all provider types in this manual are eligible to provide services in all settings. Idaho Medicaid follows the national POS codes found in the national *Current Procedural Terminology (CPT) Manual.*

3.2 Chiropractic Service Policy

3.2.1 Overview

Medicaid pays for a total of 24 spinal manipulations during any calendar year for remedial chiropractic care. Chiropractic services are limited to the manual manipulation of the spine to correct a subluxation condition.

Any claim with an injury-related diagnosis code must include the cause of the injury, and when and where the injury occurred. Enter this information in field **19** of the CMS-1500 claim form. This information may be included in the narrative field when billing electronically.

3.2.2 Prior Authorization (PA)

PA is not required for chiropractic services.

3.2.3 Covered Services

Medicaid only reimburses for treatment involving manipulation of the spine to correct a subluxation condition. Medicaid does not reimburse for any other chiropractic services.

3.2.4 Diagnosis Code

Use only the ICD-9-CM code **839** (with fifth-digit sub-classification) on all chiropractic claims for covered services, provided to Medicaid participants.

3.2.5 Modifiers

Modifiers are not required for chiropractic services.

3.2.6 Procedure Codes

Covered chiropractic services must be billed using the accepted CPT codes in the following table:

CPT Code	Description
98940	Chiropractic manipulative treatment (CMT); spinal, 1 - 2 regions.
98941	CMT; spinal, 3 - 4 regions.
98942	CMT; spinal, 5 regions.

3.2.7 Payment

Chiropractors are paid on a fee-for-service basis. The maximum fee paid is based upon Medicaid's fee schedule.

3.2.8 Healthy Connections (HC)

Medicaid participants enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care, may obtain services without a referral when those services or procedures are performed in a chiropractor's office.

3.3 Dietician Service Policy

3.3.1 Overview

Dieticians may bill the Medicaid Program directly for nutritional services provided to pregnant women. Nutritional services include intensive nutritional education, counseling, and monitoring. Either a registered dietician must render these services or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association (ADA). If a dietician works for a hospital, the hospital bills Medicaid directly for the services.

3.3.2 Covered Services and Limitations

3.3.2.1 Pregnant Women (PW) Nutritional Services

Nutritional services for women enrolled in the PW Program. All criteria listed must be met:

- Must be ordered by the participant's physician, nurse practitioner, or nurse midwife.
- Must be delivered after confirmation of pregnancy.
- Extend only through the 60th day after delivery.

Payment for two visits during the covered period is available at a rate established by DHW.

3.3.2.2 Nutritional Services for Children

Following criteria must be met:

- Ordered by a physician.
- Determined to be medically necessary

Payment for two visits during the calendar year is available at a rate established by DHW.

Children may receive two additional visits when prior authorized. Submit PA requests to:

Idaho Medicaid
Medical Care Unit
PO Box 83720
Boise, Idaho 83720-0036
Fax: (208) 332-7280

For questions regarding EPSDT PA, contact the EPSDT Coordinator at: **(208) 364-1892**.

3.3.3 Procedure Codes

Service	Code	Modifier	Description
PW nutritional services	**S9470**	**U5**	Nutritional counseling, dietician visit. The **U5** (PW) modifier is required when reporting dietician services for PW.
EPSDT nutritional services	**S9470**	No modifier required	Nutritional counseling, dietician visit.

3.4 Independent Occupational Therapists (OT)

3.4.1 Overview

Medicaid covers physician ordered OT rendered by a therapist who is licensed as an occupational therapist, as defined in, *IDAPA 22.01.09 Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants*. Medicaid services are reimbursed when provided in the participant's home or in the therapist's office.

Medicaid will cover up to 25 medically necessary OT outpatient visits, per participant, during any calendar year (January through December) without prior authorization. Visits exceeding the 25 visit limitation must be prior authorized before services are rendered. School-based services are not counted in the 25 visit limitation and do not require prior authorization.

3.4.2 Independent Therapist Qualifications

Occupational therapy (OT) services must be rendered by or under the direct supervision of a licensed OT who is identified by Medicare as an independent practitioner and enrolled as an Idaho Medicaid provider.

A therapy assistant/aide cannot bill Medicaid directly. Any services provided by an aide are not reimbursable by Medicaid.

A therapist providing services in a hospital (inpatient or outpatient), nursing facility, home health agency, developmental disability agency, or school system is not considered an independent therapist.

3.4.3 Physician Orders

For reimbursement by Medicaid, the OT must have a written order from a physician or midlevel practitioner (nurse practitioner or physician assistant). Services must be part of a plan of care (POC) based on that order. The participant's progress must be reviewed and the POC updated and reordered every 30 days by the physician or midlevel practitioner. If the therapist has documentation from the participant's primary care provider indicating that the participant has a chronic condition making therapy necessary for more than six months; then an order for continued care is required every six months.

The written physician's order must stipulate the type of OT to be provided, the frequency of treatment, the expected duration of therapy, and the anticipated outcomes along with the physician's/midlevel signature and date. The provider must maintain a copy of the POC and written physician's order in the participant's record.

3.4.4 Supervision of Occupational Therapy Assistants

Therapeutic procedures and treatment modalities, as described in the *Current Procedural Terminology (CPT) Manual*, may be performed by a licensed OT assistant when under the supervision of the appropriate therapist, as defined in *IDAPA 22.01.09 Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants.*

Independent OTs are required to provide direct supervision of the therapy assistant. Direct supervision requires that the therapist be physically present and available to render direction in person and on the premises where the therapy is being provided. The therapist is required to co-sign any documentation written by the therapy assistant. Therapy services provided by an aide are not reimbursed by Idaho Medicaid.

3.4.5 Reimbursement

Independent Occupational Therapists (OT) are reimbursed on a fee-for-service basis for services provided in the participant's home or in the provider's office. The maximum fee is based upon Medicaid's fee schedule.

The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. Office space would have to be owned, leased, or rented by the therapist/group and used for the exclusive purpose of operating the practice during those hours.

A therapist who treats participants in a nursing home or hospital, (inpatient or outpatient), a home health agency, a developmental disability agency, or in the school setting is not considered to be an independent therapist. Services provided at those locations must be billed by that entity.

Therapeutic equipment utilized by occupational therapists to provide therapeutic services to Medicaid participants is included in the fee-for-service payment and may not be charged separately (I*DAPA 16.03.09.735.01*).

3.4.6 Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho's primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral is required from the HC primary care provider (PCP) before services can be rendered.

See *Section 1 General Provider and Participant Information*, *Subsection 1.5 Healthy Connections (HC)*, for more information.

3.4.7 Post Payment Review

The POC is not required as an attachment to OT claims when submitted to Medicaid. However, the POC and documentation of services rendered must be maintained by the provider. A random sample of claims will be selected for post payment review.

When a claim is selected for review, the provider will be notified in writing by the Department of Health and Welfare (DHW). The therapist must provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of the Medicaid services billed. Medicaid will recoup the payment if proper documentation cannot be produced by the provider.

3.4.8 Prior Authorization (PA)/Procedure Codes

Providers must submit a PA request to DHW when more than 25 visits are necessary in a calendar year. PAs are valid for the dates indicated on the authorization by Medicaid. Idaho Medicaid uses nationally recognized criteria in making PA determinations. Documentation needed for determining the medical necessity for additional visits is as follows:

- OT evaluation completed during the last year.
- Current plan of care (POC) signed and dated by the physician or mid-level, completed every 30 days for acute conditions and every six months for chronic conditions. It must specify:
    - Diagnosis.
    - Modalities.
    - Anticipated short and long-term goals that are outcome-based with measurable objectives.
    - Frequency of treatment.
    - Expected duration of treatment and discharge plan.
- Reports of current status.
- Communication and coordination with other providers. Documentation may include, dates of communication, person contacted, summary of services provided by other providers, and the unique and specific contribution of this provider.
- Copies of IFSP or IEP.
- Copies of daily therapy entries completed within the last 30 days.
- Number of visits being requested.
- Date range of requested services.

The following procedure codes require PA by DHW. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to DHW that documents the medical necessity of the modality/procedure being requested. The procedures which always require a PA are as follows:

Procedure Code	Description
97039	Unlisted modality (specify type and time if constant attendance)
97139	Unlisted therapeutic procedure (specify)
97537	Community/work reintegration training (e.g., shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes

The Medical Care Unit is responsible for PA of visits in excess of 25 per calendar year, and for the three codes listed above.

Mail or fax PA requests to:

Idaho Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036
(208) 364-1904 in the Boise calling area
Fax: (208) 332-7280

When a PA is required, the PA number must be included on the claim, or the service will be denied. See *Section 2 General Billing Information, Subsection 2.3 Prior Authorization (PA)*, for more information on billing services that require PA.

3.4.9 Covered Services

3.4.9.1 Overview

Idaho Medicaid covers OT modalities, treatments, and testing as described in the Physical Medicine and Rehabilitation section of the *Current Procedural Terminology® (CPT) Manual*. The services must be:

- Within the therapist's scope of practice.
- Performed by a therapist who has received adequate training.
- Covered by Medicaid for that particular procedure and provider type.

3.4.9.2 Treatment Modalities

A modality is any physical agent applied to produce therapeutic changes to biologic tissue to include but not limited to thermal, acoustic, light, mechanical, or electric energy. Treatment modalities may be performed by the therapist or the directly supervised therapy assistant.

3.4.9.3 Therapeutic Procedures

Therapeutic procedures are the application of clinical skills and/or services that attempt to improve function. All therapeutic procedures require direct, one-on-one participant contact by the therapist or the directly supervised therapy assistant.

3.4.9.4 Tests and Measurements

Tests and measurements require the therapist to have direct, one-to-one, patient contact.

3.4.9.5 Active Wound Care Management

Wound care management requires that:

- The therapist has the appropriate training.
- The therapist has direct, one-to-one, patient contact.

3.4.9.6 Evaluations and Re-evaluations

Evaluations and re-evaluations may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service.

3.4.10 Daily Entries

According to *IDAPA 16.05.07 Section 101*:

> "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries should include the following:

- Date and time of service.
- Duration of the session (time in and out).
- Specific treatment provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the participant's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a scheduled session does not occur as scheduled, the provider must indicate the reason the plan of care was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

3.4.11 Excluded Services

Services excluded from Idaho Medicaid coverage include:

- Acupuncture (with or without electrical stimulation).
- Biofeedback services.
- Continuing services for participants who do not exhibit the capability to achieve measurable improvement.
- Services for recipients who have achieved stated goals.
- Services that do not require the skills of a therapist or therapy assistant.
- Services provided by aides or technicians.
- Massage, work hardening, and conditioning.
- Services that are not medically necessary.
- Maintenance programs.

- Duplicate services.
- Vocational programs.
- Group therapy.

3.5 Independent Physical Therapy (PT) Service Policy

3.5.1 Overview

Medicaid covers physician ordered PT rendered by a licensed physical therapist, as defined in *IDAPA 24.13.01 Rules Governing the Physical Therapy Licensure Board*. Medicaid services are reimbursed when provided in the participant's home or in the therapist's office.

Medicaid will cover up to 25 medically necessary PT outpatient visits, per participant, during any calendar year (January through December) without prior authorization. Visits exceeding the 25 visit limitation must be prior authorized before services are rendered. School-based services are not counted in the 25 visit limitation and do not require prior authorization.

3.5.2 Independent Therapist Qualifications

Physical therapy (PT) services must be rendered by or under the direct supervision of a licensed PT who is identified by Medicare as an independent practitioner and who is enrolled as an Idaho Medicaid provider.

A therapy assistant/aide cannot bill Medicaid directly. Any services provided by an aide are not reimbursable by Medicaid.

A therapist who treats participants in a hospital (inpatient or outpatient), nursing home, home health agency, developmental disability agency, or school system is not considered an independent therapist.

3.5.3 Physician Orders

For reimbursement by Medicaid, the PT must have a written order from a physician or midlevel practitioner (nurse practitioner, or physician assistant). Services must be a part of a plan of care (POC) based on that order. The participant's progress must be reviewed and the POC updated and reordered every 30 days by a physician or midlevel practitioner. If the therapist has documentation from the participant's primary care provider indicating that the participant has a chronic condition making therapy necessary for more than six months, then an order for continued care is required at least every six months.

The written physician's order must stipulate the type of PT to be provided, the frequency of treatment, the expected duration of therapy, and the anticipated outcomes along with the physician/midlevel signature and date. The provider must maintain a copy of the POC and written physician's order in the participant's record.

3.5.4 Supervision of Physical Therapy Assistants

Therapeutic procedures and treatment modalities, as described in the *Current Procedural Terminology (CPT) Manual*, may be performed by a licensed PT assistant when under the supervision of the appropriate therapist, as defined in *IDAPA 22.01.09 Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants*.

Independent PTs are required to provide direct supervision of the therapy assistant. Direct supervision requires that the therapist be physically present and available to render direction in person and on the premises where the therapy is being provided. The supervising therapist is required to cosign any documentation completed by the assistant. Therapy services provided by an aide cannot be reimbursed by Idaho Medicaid.

3.5.5 Reimbursement

Independent physical therapists (PT) are reimbursed on a fee-for-service basis for services provided in the participant's home or in the provider's office. The maximum fee paid is based upon Medicaid's fee schedule.

The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. Office space would have to be owned, leased, or rented by the therapist/group and used for the exclusive purpose of operating the practice during those hours.

A PT who treats participants in a nursing home or hospital (inpatient or outpatient), a home health agency, a developmental disability agency, or in the school setting is not considered to be an independent therapist. Services provided at those locations must be billed by that entity.

Therapeutic equipment utilized by physical therapists to provide therapeutic services to Medicaid participants is included in the fee-for-service payment and may not be charged separately (*IDAPA 16.03.09.735.01*).

3.5.6 Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral is required from the HC primary care provider (PCP) before services can be rendered.

See *Section 1 General Provider and Participant Information, Subsection 1.5 Healthy Connections (HC)*, for more information.

3.5.7 Post Payment Review

The POC is not required as an attachment to PT claims when submitted to Medicaid. However, the POC and documentation of services rendered must be maintained by the provider. A random sample of claims will be selected for post payment review.

When a claim is selected for review, the provider will be notified in writing by the Department of Health and Welfare (DHW). The therapist must provide the documentation sufficient to substantiate the amount, duration, scope, and medical necessity of the Medicaid service billed. Medicaid will recoup the payment if proper documentation cannot be produced by the provider.

3.5.8 Prior Authorization (PA)

Providers must submit a PA request to DHW when more than 25 PT visits are necessary in a calendar year. PAs are valid for the dates indicated on the authorization by Medicaid. Idaho Medicaid uses nationally recognized criteria in making PA determinations. Documentation needed for determining the medical necessity for additional visits is as follows:

- PT evaluation completed during the last year.
- Current plan of care (POC) signed and dated by the physician or mid-level, completed every 30 days for acute conditions and every six months for chronic conditions. It must specify:
    - Diagnosis.
    - Modalities.
    - Anticipated short and long-term goals that are outcome-based with measurable objectives.
    - Frequency of treatment.
    - Expected duration of treatment and discharge plan.
- Reports of current status.
- Communication and coordination with other providers. Documentation may include, dates of communication, person contacted, summary of services provided by other providers, and the unique and specific contribution of this provider.
- Copies of IFSP or IEP.
- Copies of daily therapy entries completed within the last 30 days.
- Number of visits being requested.
- Date range for requested services.

In addition, the following procedure codes always require PA by DHW. In this case, the therapist and the physician/midlevel practitioner must provide information in writing to DHW that documents the medical necessity of the modality/procedure being requested. The procedure codes which always require PA are as follows:

Procedure Code	Description
97039	Unlisted modality (specify type and time if constant attendance)
97139	Unlisted therapeutic procedure (specify)
97537	Community/work reintegration training (e.g., shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes

The Medical Care Unit is responsible for PAs for visits in excess of 25 per calendar year, and for the three codes that are listed above.

Mail or fax PA requests to:

Idaho Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036
(208) 364-1904 in the Boise calling area
Fax: (208) 332-7280

When a PA is required, the PA number must be included on the claim, or the service will be denied. See *Section 2 General Billing Information, Subsection 2.3 Prior Authorization (PA)*, for more information about billing services that require PA.

3.5.9 Covered Services

3.5.9.1 Overview

Idaho Medicaid covers PT modalities, treatments, and testing as described in the Physical Medicine and Rehabilitation section of the *Current Procedural Terminology® (CPT) Manual*. The services must be:

- Medically necessary as defined in *IDAPA 13.03.09.011.14.*
- The professional skills of a PT are required to meet the participants' therapy needs.
- Within the therapist's scope of practice and according to the standards of practice.
- Performed by a therapist who has received adequate training.
- Supervision requirements are met.
- All other Medicaid requirements are met.

3.5.9.2 Modalities

A modality is any physical agent applied to produce therapeutic changes to biologic tissue to include but not limited to thermal, acoustic, light, mechanical, or electric energy. Treatment modalities may be performed by the therapist or the directly supervised therapy assistant.

3.5.9.3 Therapeutic Procedures

Therapeutic procedures are the application of clinical skills and/or services that attempt to improve function. All therapeutic procedures require the therapist to have direct, one-on-one participant contact by the therapist or directly supervised therapy assistant.

3.5.9.4 Additional Tests or Measurements

Tests and measurements require the therapist to have direct, one-to-one, patient contact.

3.5.9.5 Active wound care management

Wound care management requires that:

- The therapist has the appropriate training.
- The therapist has direct, one-to-one, patient contact.

3.5.9.6 Evaluations and Re-evaluations

Evaluations and re-evaluations must only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service.

3.5.10 Daily Entries

According to *IDAPA 16.05.07 Section 101*:

> "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five (5) years from the date the item or service was provided".
>
> Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries should include the following:
>
> - Date and time of service.
> - Duration of the session (time in and out).
> - Specific treatment provided and the corresponding procedure codes.
> - Problem(s) treated.
> - Objective measurement of the participant's response to the services provided during the treatment session.
> - Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a scheduled session does not occur as scheduled, the provider must indicate the reason the plan of care was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

3.5.11 Excluded Services

Services excluded from Idaho Medicaid coverage include:

- Acupuncture (with or without electrical stimulation).
- Biofeedback services.
- Continuing services for participants who do not exhibit the capability to achieve measurable improvement.
- Services for recipients who have achieved stated goals.
- Services that do not require the skills of a therapist or therapy assistant.
- Services provided by aides or technicians.
- Massage, work hardening, and conditioning.

- Services not medically necessary.
- Maintenance programs.
- Duplicate services.
- Group therapy.
- Vocational programs.

3.6 Podiatry Service Policy

3.6.1 Overview

Medicaid covers podiatry services rendered for the treatment of acute foot conditions. Acute foot conditions are defined as any condition that hinders normal function, threatens the individual, or complicates any disease.

Preventive foot care may be provided in the presence of vascular restrictions or other systemic diseases.

3.6.2 Service Limitations

The following podiatry services are covered only under specific conditions:

- Care of the foot and ankle, limited to the area from the midcalf down.
- Orthotics, only if prior authorized by Medicaid.
- Muscle testing and range of motion studies, only if billed separately from outpatient visits for evaluation and management. Medicaid considers these services part of a routine office visit.
- Surgical removal of corns and calluses, only when there is systemic disease present.
- Cutting, removal, debridement or other surgical treatment of toenails, only when there is an acute condition or systemic disease present.

3.6.3 Non-Covered Services

The following podiatry services are generally not covered:

- Daily care in an inpatient hospital setting (reviewed on a case-by-case basis).
- Daily inpatient care in a skilled nursing facility, ICF/MR, or long-term care facility (the podiatrist is not the attending physician in this setting).

3.6.4 Payment

Podiatrists are paid on a fee-for-service basis. The maximum fee paid is based upon Medicaid's fee schedule.

3.6.5 Prior Authorization (PA)

Prior authorization (PA) is not required for podiatrist procedures, except for orthotics. If PA is required, the PA number must be included on the claim form or the service will be denied.

See *Section 2.3.2 Medicaid Prior Authorization (PA)*, for more information on billing services that require PA.

3.6.6 Procedure Codes

All claims must use the appropriate 5-digit CPT procedure codes and if applicable, modifiers. Refer to the *Current Procedural Terminology (CPT)* Manual for the appropriate codes.

3.6.7 Diagnosis Code

All claims must list the appropriate ICD-9-CM diagnosis code for acute conditions. The acute condition must be indicated on the initial claim and all subsequent claims.

3.6.8 Healthy Connections (HC)

Medicaid participants enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care, may obtain services without a referral if those services/procedures are performed in a podiatrist's office.

However, procedures that are performed in an inpatient or outpatient hospital or ambulatory surgery center (ASC) setting require a referral from the primary care provider (PCP) for the facility and the ancillary physicians/providers such as pre-operative examination by a physician.

3.7 Radiology Technician Service Policy

3.7.1 Overview

Radiology services have both a technical and professional component. Radiology technicians can have their own provider number and bill for the technical component if they own, rent, or lease the equipment used for the radiology service. If the radiology technician does not own, rent, or lease the equipment, the technical component is billed by the physician, clinic, or facility owning the equipment.

3.7.2 Covered Services

The technical component includes charges for the following:

- Personnel.
- Material, including usual contrast media and drugs.
- Film or xerograph.
- Space, equipment, and other facility charges.

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. To be assured of adequate reimbursement, attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs to providers and the radioisotopes billed, this information is necessary to adequately price each claim.

3.7.3 Modifiers

To identify a charge for the technical component use the appropriate 5-digit CPT procedure code with the **TC** modifier.

3.7.4 Mobile Imaging Units

If the radiology technician owns, leases, or rents the mobile radiology equipment, they must:

- Be enrolled as a provider type and specialty 023/218 (healing arts provider type, radiology technical services specialty).
- Provide proof of ownership, lease, or rental agreements for this provider type.
- Providers billing for services in a mobile imaging unit must bill with POS 15 (Mobile Unit).

3.7.5 Procedure Codes

Idaho Medicaid uses CPT codes found in the current version of the *Current Procedural Terminology (CPT) Manual under Diagnostic Radiology* (Diagnostic Imaging **70010** - **76499**).

3.7.6 Payment

Only the technical component of radiology services should be billed. Payment is at a rate established under the provisions of *IDAPA 16.03.09.230.02 Medicaid Basic Plan Benefits; General Payment Procedures; Individual Provider Reimbursement*.

3.8 Social Work

3.8.1 Overview

Social workers are only paid directly for providing physician ordered pregnancy related services. Individual and family social services, limited to two visits during the covered period, are allowed when directed at helping a participant to overcome social or behavioral problems which may adversely affect the outcome of the pregnancy. Services to assist the participant in obtaining medical, educational, social, and other services necessary to assure a positive pregnancy outcome are also allowed.

3.8.2 Payment

Payment is available to licensed social workers either in independent practice or as employees of entities that have current provider agreements with DHW. Payment is at a rate established under the provisions of, *IDAPA 16.03.09.230.02 Medicaid Basic Plan Benefits; General Payment Procedures; Individual Provider Reimbursement*.

Service is limited to two visits during the covered period by a licensed social worker qualified to provide individual counseling according to the provisions of Idaho Code and the regulations of the Board of Social Work Examiners.

3.8.3 Procedure Codes

HCPCS	Modifier	Description
S9127	**U5** (PW Program)	Social work visit, in the home, per diem. (Individual and family social services.) Modifier **U5** is required.

3.9 Independent Speech-Language Pathologist

3.9.1 Overview

Medicaid covers physician-ordered speech-language pathology (SLP) services rendered by a licensed SLP, as defined in *IDAPA 24.23.01 Speech and Hearing Services Licensure Board*. Medicaid services are reimbursed when provided in the participant's home or in the therapist's office.

Medicaid will cover up to 40 medically necessary SLP outpatient visits per participant during any calendar year (January through December) without prior authorization. Visits exceeding the 40 visit limitation must be prior authorized before services are rendered. School-based services are not counted in the 40 visit limitation and do not require PA.

3.9.2 Independent Therapist Qualifications

Speech-language pathology (SLP) services must be rendered by a licensed therapist licensed by the Board of Occupational Licensing, Speech and Hearing Services Licensure Board, and enrolled as an Idaho Medicaid provider.

A therapist who treats participants in a nursing home or hospital, inpatient or outpatient, home health agency, developmental disability agency, or school system is not considered an independent therapist. Services provided at those locations must be billed by that entity.

3.9.3 Physician Orders

For reimbursement by Medicaid, the SLP must have a written order from a physician or a midlevel practitioner (nurse practitioner or a physician assistant). Services must be part of a plan of care (POC) based on that order. The participant's progress must be reviewed and the POC updated and reordered every 30 days by a physician or midlevel practitioner. If the therapist has documentation from the participant's primary care provider indicating that the participant has a chronic condition making therapy services necessary for more than six months; then an order for continued care is required at least every six months.

The written physician's order must stipulate the type of SLP services needed, the frequency of treatment, the expected duration of therapy, and anticipated outcomes along with the physician's signature and date. The provider must maintain a copy of the POC and written physician's order in the participant's record.

3.9.4 Supervision

Services provided by speech-language pathology assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as SLP services except as allowed in school-based services.

3.9.5 Reimbursement

Independent speech-language pathologists are paid on a fee-for-service basis for services provided in the participant's home or in the provider's office. The maximum fee paid is based upon Medicaid's fee schedule.

The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. Office space would have to be owned, leased, or rented by the therapist/group and used for the exclusive purpose of operating the practice during those hours.

A therapist who treats participants in a nursing home or hospital, (inpatient or outpatient), a home health agency, a developmental disability agency, or in the school setting is not considered to be an independent therapist. Services provided at those service locations must be billed by that entity.

3.9.6 Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral is required from the HC Primary Care Provider (PCP) before services can be rendered.

3.9.7 Post-Payment Review

The POC is not required as an attachment to speech-language pathology claims when submitted to Medicaid. However, the POC and documentation of services rendered must be maintained by the provider. A random sample of claims will be selected for post-payment review.

When a claim is selected for review, the provider will be notified in writing by the Department of Health and Welfare. The therapist must provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of the Medicaid service billed. Medicaid will recoup the payment if proper documentation cannot be produced by the provider.

3.9.8 Prior Authorization (PA)

Providers must submit a PA request to DHW when additional visits are needed over 40 visits in a calendar year. PAs are valid for the dates indicated on the authorization by Medicaid. Documentation needed for determining the need for additional visits is as follows:

- SLP evaluation completed within the past year.
- Current plan of care (POC) signed and dated by the physician or mid-level, completed every 30 days for acute conditions and every six months for chronic conditions. It must specify:
    - Diagnosis.
    - Modalities.
    - Anticipated short and long-term goals that are outcome-based with measurable objectives.
    - Frequency of treatment.
    - Expected duration of treatment and discharge plan.
- Reports of current status.
- Communication and coordination with other providers. Documentation may include, dates of communication, person contacted, summary of services provided by other providers, and the unique and specific contribution of this provider.
- Copies of IFSP or IEP.
- Copies of the daily entries completed within the last 30 days.
- Number of visits being requested.
- Date range of requested services.

The Medical Care Unit is responsible for speech-language pathology PAs for visits in excess of 40 per calendar year. Mail or fax PA requests to:

Idaho Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036
(208) 364-1904 in the Boise calling area
Fax: (208) 332-7280

When a PA is required, the PA number must be included on the claim, or the service will be denied. See *Section 2.3.2 Medicaid Prior Authorization (PA)*, for more information on billing services that require PA.

3.9.9 Covered Services

Idaho Medicaid covers SLP evaluation and treatment of speech, language, voice, communication, and/or auditory processing as described in the *Current Procedural Terminology (CPT) Manual*.

3.9.10 Daily Entries

According to *IDAPA 16.05.07 Section 101*:

> "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five (5) years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries should include the following:

- Date and time of service.
- Duration of the session (time in and out).
- Specific treatment provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the participant's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a scheduled session does not occur as scheduled, the provider must indicate the reason the plan of care was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

3.9.11 Excluded Services

Services excluded from Idaho Medicaid coverage include:

- Continuing services for participants who do not exhibit the capability to achieve measurable improvement.
- Services for recipients who have achieved stated goals.
- Services that address developmentally acceptable error patterns.
- Services that do not require the skills of a therapist.
- Services provided by assistants, aides, or technicians.
- Services that are not medically necessary.
- Maintenance programs.
- Duplicate services.
- Group therapy.

3.10 Claim Billing

3.10.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.10.2 Electronic Claims

For PES software billing questions, consult the Provider Electronic Solutions (PES) Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission*, for more information.

3.10.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Code: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See Section 3.18.6.3 in the Physician Guidelines, for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.10.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006.

3.10.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items, per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature-on-file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.10.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.10.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

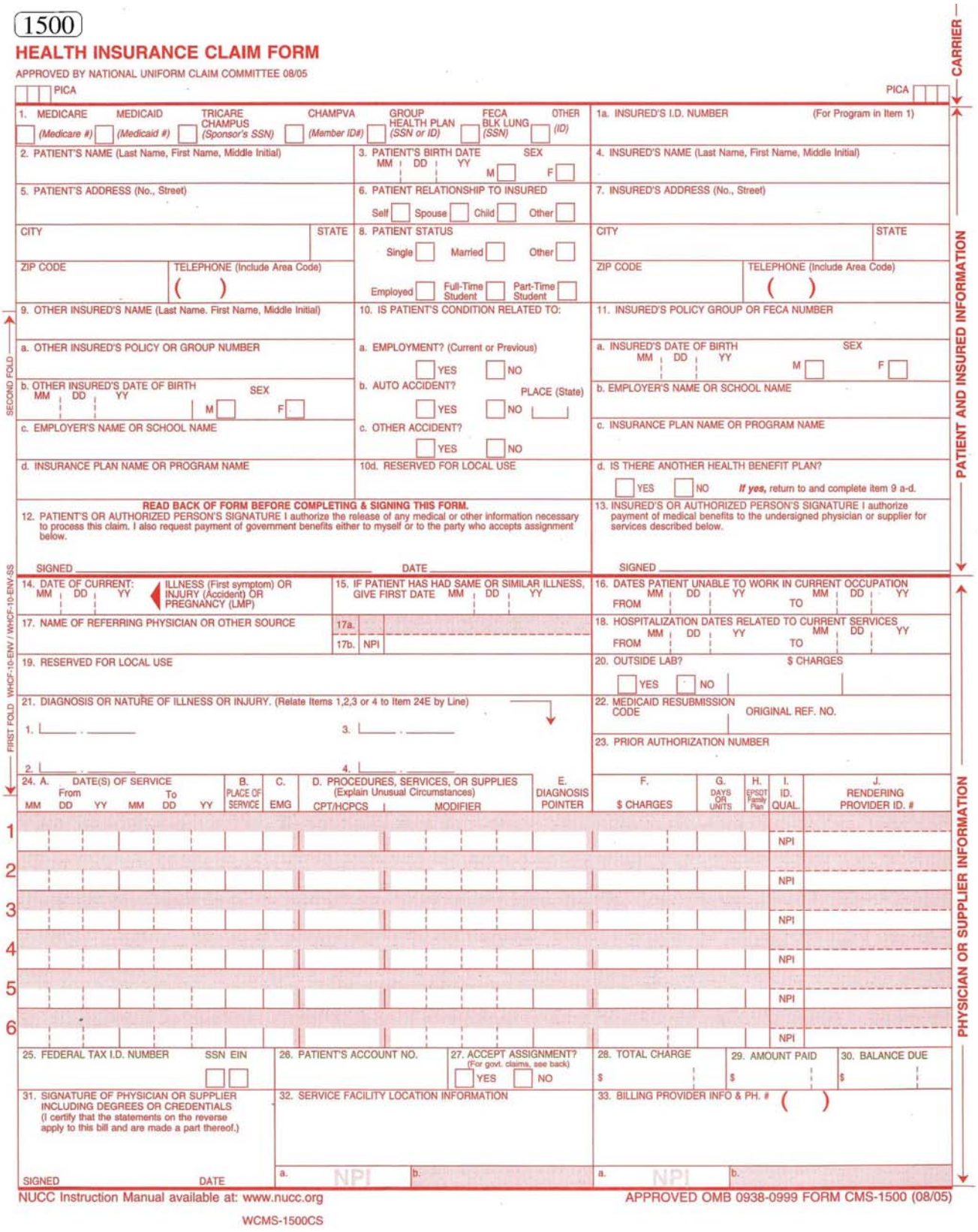
Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient's Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient's Condition Related To Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient's Condition Related To Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current: Illness, Injury or Pregnancy (LMP)	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HCs participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HCs participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HCs participants, enter the qualifier **1D** followed by the 9-digit HCs referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit national provider identifier (NPI) number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the internal control number (ICN) of previous claims to establish timely filing.

Field	Field Name	Use	Directions
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate *ICD-9-CM* code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the *ICD-9-CM* primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date(s) of Service From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedure, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedure, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield **(1 - 4)** for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each detail line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program screen; see *Section 1.6 EPSDT,* for more information.
24I	ID Qual	Required, if legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field, if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-On-File Form*, or more information.

Field	Field Name	Use	Directions
33	Billing Provider Info & Ph	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or remittance advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment in writing so that the provider master file can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.10.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS